

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: 3142a Michigan  
(d) Length of stay: In hospital or institution (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 19  
(d) Street No. 3142a Michigan 9  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Agnes Cebe  
3. (b) If veteran, name war  
3. (c) Social Security No. 489-10-3159

4. Sex F / 5. Color or race W  
6. (a) Single, widowed, married, divorced / Married  
6. (b) Name of husband or wife Dan Cebe  
6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased 4-23-1909 (Month) (Day) (Year)

8. AGE: Years 38 Months 10 Days 20 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Shoemaker

11. Industry or business Mellies Shoe Co.

MOTHER FATHER { 12. Name Charles Shofr  
13. Birthplace Czechslovakia (b) (City, town, or county) (State or foreign country)  
14. Maiden name Julia Kloda  
15. Birthplace Szechnoslovakia (b) (City, town, or county) (State or foreign country)

16. (a) Informant Dan Cebe  
(b) Address 3142a Michigan

17. (a) Uremation (b) Date thereof 3-16-48 (Month) (Day) (Year)  
(c) Place: burial or cremation Missouri Urematory

18. (a) Signature of funeral director Thomas Kutis & Son  
(b) Address 2906 Gravois

19. (a) MAR 15 1948 (b) J. F. Breese (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MARCH day 25-13 year 1948 hour 1:45 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 5, 1947 to Mar. 13, 1948; that I last saw her alive on Mar. 13, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of heart and myocardial failure  
Due to Bronchial asthma over 1 yr.

Due to 112  
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Of operations  
Of autopsy  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Robert S. Nye M.D. (Specify type of place) (e) Means of injury  
Address 3201 Grand St. Date signed 15 Mar 48

WRITE PLAINLY—USE UNFAINT BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Leop. Budde*

Licensed Embalmer No.

*3989*

P. O. Address.....

*St. Louis, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**